National Health Insurance
Caveat Emptor

A DECISION TO ENACT SOME kind of health insurance fairly soon has apparently been made. The proposals before the Congress and the presentations at the hearings being held at the time of this writing offer a wide spectrum of different and largely incompatible attitudes and approaches. The rather sudden decision to proceed at this time suggests that what will be enacted has now been more or less decided, although what this is has yet to be revealed. Assuming this is the case, we say *caveat emptor*, let the buyer beware, for there is a great deal not yet known either about what should be purchased or what it should be worth and to whom.

National health insurance will be buying something for which there is as yet no clear description or specification. Is it health, as the term itself would imply, and if so what is the definition of health to be used? Or is it health care, and if so precisely what is involved in this, or is it medical care, and if so how much of what for whom? Much of what is to be purchased, including physician-patient relationships, has yet to be defined, and its value has yet to be determined in ways which will be acceptable and standard across the nation. Until questions such as these can be answered, confusion, dissatisfaction and waste of dollars are inevitable.

The decision to proceed with national health insurance is considerably the result of rhetoric which has unfortunately been based largely upon myths and slogans which have been repeated so often that they have now become accepted as truisms. The untruth of many of these statements and assumptions which seem to underlie so many of the proposals now under consideration, will sooner or later, and after millions or billions of dollars, become evident. The sad reality will be that dollars and scarce resources which could have been more wisely used will have been wasted in obeisance to myths which have been accepted as truths.

So far no realistic thinking is apparently being given to what the relationship can be between scientific and technical progress and the numbers and kinds of services which will have to be paid for by national health insurance. As science and technology progress, services will become more numerous and more frequently rendered, and they will cost more. This can only be curtailed by reducing support for medical research as a kind of preventive measure, or by restricting the kinds, frequency or expense of the services to be rendered. Actually both have already begun. The federal government has substantially reduced its support of medical research and the state restricts the services available to patients under its Medi-Cal program for the care of indigents. Yet if national health insurance is to be in the long run good for the nation, it seems that it should somehow encourage more research rather than less, and more and better patient care services rather than less.

There are many indications that national health insurance will propose more organization and system in the delivery of medical and health care services with the intent of producing more services at less cost. Experience would suggest that this is likely to prove a contradiction in terms, since more organization and more delegation and distribution of tasks tends to increase costs although it may also increase the number of services rendered. However, the opinion that costs can be reduced by more system is so widely held that national health insurance may squander considerable money and other resources in pursuit of this mirage.

Finally, one wonders how much national health insurance will be concerned with either

consumer or provider satisfaction with the plan or its services. There is little evidence so far that either the consumer or the provider has been consulted to any extent in the preparation of proposals, yet it stands to reason that the one must receive its benefits and the other deliver them, and that both must be satisfied if things are to go smoothly and well.

The writer of this editorial is fully aware that what is said here or anywhere else is not likely to have much influence at this late date. But it is to be hoped that those who have the power and determination to enact national health insurance, whether it be this year or next year or sometime thereafter, will give some thought to the enormous impact of what they are doing, to the relative absence of firm data upon which to base this action, and to the real possibility that whatever controls and restraints they impose may have the effect of reducing rather than increasing the amount of health care which would otherwise have been rendered to the people of this nation.

The California Medical Association along with many others believes that some form of national health insurance is now needed, and along with many others CMA has submitted its own proposal to the Congress. It is quite obvious that none of these proposals will be accepted as they stand. We now await with interest and no little apprehension the apparently imminent revelation of the plan for national health insurance which will be debated and probably eventually enacted in some form by the Congress. We know that it can only be based on insufficient and often inaccurate information and on inadequate data since the necessary information and data simply do not exist. So again we say *caveat emptor.*

—MSMW

Renal Allograft Rejection

THE DIAGNOSIS OF THE REJECTION process in a human renal allograft remains a baffling and frustrating problem. To date, there exists no satisfactory method of diagnosing the rejection process itself, and, therefore, we must fall back upon functional changes in the transplanted kidney itself. Because such changes may be mimicked by a number of processes other than rejection or the kidney affected by other insults in addition to rejection, the problem of when to treat the allograft rejection, and how vigorously, is constantly with the clinician who cares for such patients. The tools available for suppressing or reversing rejection process are much too dull and nonspecific. In addition to affecting the rejection process itself, they impair a good many functions which protect the integrity of other organs. Thus, azathiaprine, the basis of present immunosuppressive therapy, impairs protection against bacteria, yeasts, and probably even the spontaneous development of lymphoid tumors. Massive doses of corticosteroids, which are the only truly effective method of reversing rejection, obviously impair wound healing, the localization of infection, and cause gastrointestinal bleeding. Were one to develop an effective, simple, and infallible test for the rejection of a kidney transplant, one might treat the process earlier and with smaller amounts of immunosuppressive agents, thus preventing damage to the allograft and to the host as well. Unfortunately, morphologic and functional changes which may be confused with changes not related to the rejection process, are the best, but still unsatisfactory, indices of kidney rejection.

This is the issue to which Mr. W. J. Dempster of the Royal Post Graduate Medical School of London addresses himself in an article elsewhere in this issue of CALIFORNIA MEDICINE.

However, his discussion includes considerably more than is indicated by the title of his article. Many of his opinions will not be shared by other workers in the transplantation field—but this has never deterred Dempster from expressing them. He has been in the business of transplanting kidneys for a long while, certainly from the beginning of the modern era, and he writes with the assurance which springs from long familiarity with the problem. His were some of the earliest and most fundamental observations on the functional and pathologic characteristics of the transplanted dog kidney. I was fortunate in being able to visit him in 1953 and observe his work at first hand. At that time, his laboratories were situated in the magnificent Buxton Browne Research Farm, the site of Charles Darwin's former home. His animal experiments were carried out